

**UWEM UMOH**  
**ATTORNEY AT LAW**  
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BY EMAIL AND HAND

June 15, 2008

Harold Derschowitz, Esq.  
Lester Schwab Katz & Dwyer, LLP  
120 Broadway  
New York, NY 10271

Re: Jordan Mann v. Plus One Fitness et al.  
07 CV 5691(RB)

Dear Harold Derschowitz:

This letter is written in response to your May 30, 2008 letter. The numbers below correspond to the responses in your Notice to Produce that you deemed deficient.

1. Plaintiff is not in possession of any communication between herself and any defendant in this action.
2. Bob Welter and plaintiff are the speakers on the CD previously provided to defendants.
4. Plaintiff refers defendants to documents Bates Stamped JM0008 to JM0184.
5. Plaintiff refers defendants to documents Bates Stamped JM0123 to JM0128.
6. Plaintiff is not in possession of any employment contracts between herself and defendants.
7. Plaintiff received treatment as a result of the claims made in her second amended complaint from :

Retha Buck treated plaintiff through insurance at Plus one. She treated plaintiff from April 2006 to late June 2006 and can be reached at 2115 Millburn Ave Ste.100. Maplewood, NJ 07040. Her work number is 973-761-1242

Marlene Friedman was seen through Medicaid. June 2007 to August 2007.

Dr. Ann Boris treated plaintiff from August 2007 to September 2007. Plaintiff currently does not have the address of this doctor, but Dr. Boris treated her through Medicaid.

Crystal Huggins, plaintiff's reverend counseled her from June 2006 to February 2008. She can be reached at 212-696-8528.

8. Plaintiff is not in possession of her taxes from 2006 and 2007. Authorizations are enclosed herein. Plaintiff produced copies of her 2005 taxes, Bates Stamped JM 0207.
9. Plaintiff refers defendants to documents Bates Stamped JM 0001- JM0224. Plaintiff reserves the right to supplement this response as she unsure of all the documents she may present at trial.
10. Plaintiff refers defendants to the disk CD produced containing a conversation between herself and Bob Welter.
11. Plaintiff is not in possession of any statement, written or oral, of any party represented in this action.
12. A picture of plaintiff's hair is attached to this email. The picture was taken during the period of plaintiff's employment at Plus one.

Sincerely,

/s  
NKEREUWEM UMOH

Cc:

DEBORAH MARTIN NORCROSS  
MARTIN NORCROSS, LLC  
110 WALL STREET, RCG SUITE 26<sup>th</sup> FLOOR  
NEW YORK, NEW YORK 10004

**SOUTHERN DISTRICT OF NEW YORK**

Social Security No.: 147-78-1209

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name <u>Jordan Mann</u>	Date of Birth <u>10/8/68</u>	Social Security Number <u>147-78-1209</u>
Patient Address <u>80 Saint Nicholas Ave<sup>5A</sup>, New York, NY 10026</u>		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

Retha Buck 2115 Milburn Ave, Ste. 100 Maplewood, NJ 07040

8. Name and address of person(s) or category of person to whom this information will be sent:

Harold Derschwitz, Esq, Lester Schwab Katz, & Dwyer LLP

9(a). Specific information to be released:

☒ Medical Record from (insert date) April 1, 2006 to (insert date) Present☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.☐ Other: \_\_\_\_\_

Include: (Indicate by Initialing)

☒ **Alcohol/Drug Treatment**☒ **Mental Health Information**☒ **HIV-Related Information****Authorization to Discuss Health Information**(b) ☐ By initialing here \_\_\_\_\_ I authorize \_\_\_\_\_

Initials

Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

☒ At request of individual☐ Other:

11. Date or event on which this authorization will expire:

End of litigation

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 6/16/08

Signature of patient or representative authorized by law.

\* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA****[This form has been approved by the New York State Department of Health]**

Patient Name <u>Jordan Mann</u>	Date of Birth <u>10/8/68</u>	Social Security Number <u>147-78-1209</u>
Patient Address <u>80 Saint Nicholas, Apt 5A, New York, NY 10026</u>		

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1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

Medicaid New York State Department of Health, 26 Federal Plaza, Rm 3811, NY, NY 10278

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☒ Medical Record from (insert date) 6/2007 to (insert date) Present  
☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: \_\_\_\_\_

Include: (Indicate by Initialing)

- ☒ **Alcohol/Drug Treatment**  
☒ **Mental Health Information**  
☒ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ☐ By initialing here \_\_\_\_\_ I authorize \_\_\_\_\_  
Initials Name of individual health care provider  
to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual  
☐ Other: \_\_\_\_\_

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: \_\_\_\_\_

Signature of patient or representative authorized by law.

\* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

NEW YORK STATE  
**BENEFIT**  
IDENTIFICATION CARD



ID NUMBER: RA30663D CARD NUMBER: 600485 8722 1306 631 03

SEX: F DOB: 10/08/1968

LASTNAME: MANN

FIRST NAME (ALL): RHONDA

*Rhonda Mann*



ADDRESS NUMBER: 8722 1306 631 03

Department of the Treasury  
Internal Revenue Service

Do not sign this form unless all applicable lines have been completed.  
Read the instructions on page 15.  
Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

**Tip:** You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first. **Rhonda Mann AKA Jordan Mann**  
1b First social security number on tax return or employer identification number (see instructions) **147-78-1209**  
2a If a joint return, enter spouse's name shown on tax return  
2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

**Harold Derschowitz, Esq.** **120 Broadway**  
**Lester Schaub Katz & Dwiger, LLP** **New York, NY 10271**

**Caution:** If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.

6 Tax return requested (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. **1040**  
Note. If the copies must be certified for court or administrative proceedings, check here. ☐

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

**02/01/2006** **01/01/2007**

8 Fee. There is a \$39 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	\$ 39.00
b Number of returns requested on line 7	2
c Total cost. Multiply line 8a by line 8b	\$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here ☒

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

**Rhonda Mann** Telephone number of taxpayer on line 1a or 2a ( )  
Signature (see instructions) Date  
Title (if line 1a above is a corporation, partnership, estate, or trust)  
Spouse's signature Date